907 KAR 1:008
Ambulatory Surgical Center Services and Reimbursement

Material Incorporated by Reference

Ambulatory Surgical Center Services and Reimbursement Manual
(October 2002 edition)

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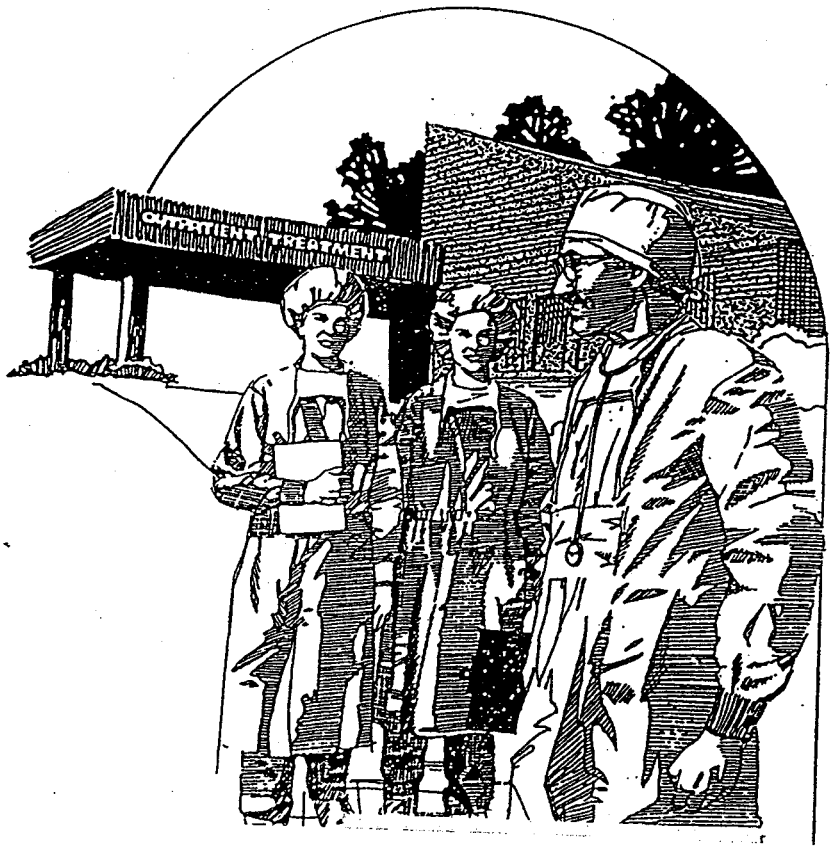
MEDICAID SERVICES MANUAL
For
Ambulatory Surgical Centers

KENTUCKY MEDICAID PROGRAM



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and Reimbursement Manual

(October 2002 edition)

Filed: _____

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

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SECTION I

SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Ambulatory Surgical Centers Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage, policy and reimbursement. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable payment.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Facsimilies, stamped or computer generated signatures shall be not acceptable.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d)(5) as follows, "The date of receipt is the date the agency receives the claim as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between **EACH RECEIPT** of the aged claim by the Program.

C. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

D. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Ambulatory Surgical Center numbers have a prefix of "36". This number serves to identify statements submitted to the program, and shall be utilized in the preparation of all payment records. Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated or suspended from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date shall not be payable.

B. Provider Freedom of Choice

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided.

C. Medicaid Participation Overview

Any ambulatory surgical center licensed by its respective state and certified for participation under Title XVIII (Medicare) may upon approval of the Department, participate in the Kentucky Medicaid Program by completing participation agreements and requesting payment for covered medical services provided to eligible program recipients. A copy of this license or any renewal of license shall be submitted by the provider and maintained on file in the Department. All participating providers shall comply with the requirements specified in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Ambulatory surgical centers located outside the United States and its territories shall not be granted enrollment in the Kentucky Medicaid Program.

D. Medical Records

Providers shall maintain comprehensive legible medical records as are necessary to fully disclose and substantiate the extent of the medically necessary services provided. Physician notes shall be contained in these medical records (if applicable). These notes shall be entered personally by the physician or may be typewritten if signed by the physician. All records shall be signed and dated.

Medical records of Kentucky Medicaid Program recipients shall be maintained by the provider for a period of not less than five (5) years from the date of service or additional time as necessary in the event of an audit exception or other dispute. These records, and any of the information regarding Medicaid Program paid claims, shall be maintained in an organized central file, furnished to the Department or its authorized representative as requested, and made available for inspection and photocopy. Notification in writing shall be made to the Medicaid Program regarding any change in Program participation status (e.g., change of ownership, address change, closing).

E. Overview of Required Procedures

The Medicaid Program shall use several investigative and screening methods to detect any abuse on the part of the provider or recipient. Computer print-outs shall be reviewed periodically. Data shall be compared against norms of the specific medical service areas for number of medical services per recipient, cost per service and cost per recipient. If the figures show significant deviations from the norms, the provider shall be identified as needing an in-depth review. Records shall be more thoroughly examined and provider and recipient contacts shall be initiated to determine the cause for the unusual pattern of care.

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

A. Covered Ambulatory Surgical Center (ASC) Services and Associated Reimbursement Limitations

The Kentucky Medicaid Program shall provide reimbursement for allowable procedures and services provided by licensed, certified Ambulatory Surgical Centers (ASC's) enrolled in the Program. Reimbursement for elective procedures or services performed by ASC's shall be subject to prior authorization approval by the Peer Review Organization (PRO) contractor. (See Appexdix A for a listing of these procedures). Prior authorization means that the PRO shall authorize and approve the procedure or services before the provider may submit a bill and receive reimbursement for the procedure or service. Approval of procedures or services requiring prior authorization shall be obtained from the PRO by the provider before the procedure or services are provided. A prior authorization (certification) number shall be assigned by the PRO for the approved services and issued to the provider or provider staff. The authorization number shall then be entered in the appropriate field on the claim form when billing the Program. If the PRO has not approved the procedure or service the ASC **shall not** be reimbursed by Kentucky Medicaid for the procedure or services provided.

Facility services include but are not limited to the following:

1. Laboratory Services

   An ambulatory surgical center may make arrangements or contract with others to furnish covered outpatient items and services.

a. If an ambulatory surgical center obtains laboratory or other services under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII. In these cases where the Medicaid Program makes payment for services provided to the recipient, receipt of payment by the ambulatory surgical center for those services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the recipient and the Program of further liability.

b. Only ASC laboratories which possess a certificate of accreditation (a 10 digit CLIA number) shall be eligible for reimbursement for laboratory services provided.

2. Use of the Ambulatory Surgical Center Facilities.

3. Drugs, Biologicals (e.g., blood), Surgical Dressings, Splints, Casts and Appliances and Equipment Directly Related to the Provision of Surgical Procedures.

4. Diagnostic or Therapeutic Services or Items Directly Related to the Provision of a Surgical Procedure.

5. Materials for Anesthesia.

6. Intraocular Lenses.

7. Dental Procedures.

   Procedure D0110 - Comprehensive Oral Evaluation (limited to one (1) per twelve (12) month period, per provider, per recipient). Procedure D0110 shall not be billed in conjunction with procedure D0130 - Emergency Call - trauma related.

   Procedure D0130 Emergency Call - Intermediate Level of Service, (trauma related injuries only) e.g., fractured teeth, soft tissue trauma, dental injuries sustained from a motor vehicle accident, avulsed teeth, alveolar bone fractures, lacerations, circumoral burns, and other unusual oral injuries. Only one (1) emergency may exist during any one (1) visit, even though treatment may involve more than one (1) procedure or tooth.

   Procedure D0210 - Intraoral - Complete series (including bitewings). An intraoral complete series consists of four (4) bitewings and fourteen (14) periapicals. Limit: One (1) per twelve (12) month period, per provider, per recipient.

8. Induced Termination of Pregnancy

   Induced termination of pregnancy shall be covered in accordance with KRS 205.560 and subject to other program edits.

   In cases of induced termination of pregnancy or miscarriage, the appropriate certification form(s) (MAP-235 or MAP-236) indicating the procedure performed, shall be completed and signed by the physician. A copy of the completed form and an **operative report** shall accompany each claim submitted for payment to Kentucky Medicaid. See Appendix B and C for examples of these forms.

9. Sterilization Procedures

Sterilization (both male and female shall be reimbursable by the Medicaid Program **only** when performed in compliance with federal regulations (42 CFR 441.250) which are as follows:

a. The consent form (MAP-250, Rev. 1/79) shall be signed and dated by the recipient and the person obtaining the consent at least **thirty (30) days prior to** the sterilization, except in cases of premature delivery or emergency abdominal surgery. In these specific situations, reimbursement shall be allowed if at least seventy-two (72) hours have elapsed from the time the consent form for sterilization is signed and dated. In the case of premature delivery, the consent form shall be signed at least thirty (30) days before the **expected date of delivery.** Not more than 180 days shall elapse between the date the consent form is signed and the date of the sterilization procedure.

b. The physician who performs the procedure shall **sign and date the physician statement of the MAP-250 after** the sterilization procedure has been performed.

c. The recipient being sterilized shall be at least **twenty-one (21)** years of age at the time consent is obtained.

d. The recipient is not mentally incompetent. For program purposes, "mentally incompetent individual" is defined as a person who has been declared incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

e. The recipient is not institutionalized. For program purposes, "institutionalized individual" is defined as an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

f. The recipient has been given a thorough explanation of all elements of the department's approved consent to sterilization form prior to giving consent for the procedure to be performed. In addition, the recipient must have been made fully aware that he or she is free to withhold consent to the procedure at any time before the sterilization, without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled. In instances where the individual is blind, deaf, or otherwise handicapped, arrangements shall be made to ensure that all information is effectively communicated. Similarly, an interpreter shall be provided if the recipient to be sterilized did not understand the language of the consent form or of the person obtaining the consent.

g. The informed consent shall not be obtained while the recipient to be sterilized is in labor or childbirth; under the influence of alcohol or other substances that affect the individual's state of awareness; or seeking to obtain or obtaining induced termination of pregnancy.

These regulations shall apply to any medical procedures performed for the purpose of producing sterility.

h. All applicable spaces of the MAP-250 shall be completed. All claims submitted to the department for sterilization, whether performed as a primary or secondary procedure, or for medical procedures directly related to such sterilization's, shall include a copy of the signed consent form and an **operative report**.

i. If a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal, etc.) and federal regulations governing payment for the sterilization have not been met, Kentucky Medicaid shall make payment **ONLY** for covered non-sterilization procedure(s).

j. Claims for unilateral or laproscopic surgical procedures which could possibly result in sterilization shall be submitted with attached documentation verifying that the recipient was not sterilized as a result of the performed procedure.

Application of policy related to all covered services shall be subject to enforcement by the postpayment review of claims.

NOTE: An example of a completed Sterilization Consent Form is contained in Appendix D.

10. Hysterectomy Procedures

Title XIX funds shall be expended for hysterectomies that are medically necessary **ONLY** under the following conditions:

a. The person who secures the authorization to perform the hysterectomy shall inform the recipient or her representative, if any, orally and in writing, that the hysterectomy shall render her permanently incapable of reproduction

and

b. The recipient or her representative, if any, shall sign and date the Hysterectomy Consent Form (MAP-251) prior to the procedure.

A copy of this Hysterectomy Consent Form (MAP-251) and an **operative report** shall accompany each claim submitted for payment for the hysterectomy, **EXCEPT** in the following situations:

a. The recipient is sterile at the time of the hysterectomy and this is supported by medical documentation submitted with the claim form

or

b. The recipient requires a hysterectomy because of a life-threatening emergency and the physician determines that prior acknowledgment of resulting sterility is not possible.

The physician shall certify in writing either the cause of the previous sterility or that the hysterectomy was performed under a life-threatening emergency situation in which he determined prior acknowledgment was not possible. The physician shall also include, if applicable, a description of the nature of the emergency. This documentation shall accompany any claim for a hysterectomy procedure for which a Hysterectomy Consent Form (MAP-251) was not obtained.

If a hysterectomy is performed for an individual during a period of **retroactive eligibility,** the physician shall certify in writing that the Kentucky Medicaid Program recipient was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt exceptions was applicable at that time.

An example of a completed Hysterectomy Consent Form is contained in Appendix E.

11. Procedures Requiring Reports

All services reimbursed by Kentucky Medicaid shall be medically necessary, medically appropriate and related to the diagnosis and treatment of illness or injury, impairment, or maternity care. Documentation in recipient medical records shall support necessity and substantiate the level of service billed. Medically necessary services shall be defined as those services which:

- are in accordance with standards of good medical practice;
- are indicated for and consistent with the diagnosis of the recipient; and
- reflect the most appropriate level of care in the most appropriate setting.

A number of services shall be reimbursed by Kentucky Medicaid **ONLY** when appropriate legible documentation is attached to claims submitted for payment. Acceptable documentation (e.g., operative note, consent forms, history and physical report, consultation findings, etc.) shall include the following information:

1. name of recipient and date of service,
2. a complete description of the service performed,
3. physician provider's signature, and
4. name of referring physician, if appropriate (e.g., consultations).

Additional documentation may be requisitioned as necessary by Department for Medicaid staff to support that services provided were medically necessary, to assure the quality of service delivery, or to substantiate the level of service delivery.

NOTE: Procedure codes for unlisted procedures ending in "99", e.g., 58999, shall be reserved for unusual circumstances and shall not be used when another procedure code that closely identifies the procedure performed is available for billing purposes.

B. Non-Covered Ambulatory Surgical Center (ASC) Services

Services or procedures **not covered** by Kentucky Medicaid shall include but not be limited to the following:

- Acupuncture Services;
- Any services not performed in compliance with state and federal requirements (i.e., sterilization, hysterectomy, and induced termination of pregnancy procedures);

- Any services determined by the Department as not medically necessary. If the attending physician determines the procedure is medically necessary, documentation to support the medical necessity shall be submitted to the Division of Individual and Clinic Providers for consideration;

- Artificial insemination or procedure(s) for the treatment of infertility, including procedures for the reversal of a voluntary sterilization;

- Biofeedback Services;

- Call back/stat and handling or processing fees;

- Dental procedures for routine dental care not considered "high risk";

Note: "High risk" recipients are those with heart disease, mental retardation, high blood pressure, etc.:

- Duplicate services;

- Extra "cuts" on CAT scans or extra radiological views;

- Forensic study services;

- Handling and processing fees associated with service delivery;

- Hysterectomies performed for sterilization purposes;

- I.V. infusion therapy (for maintenance or replacement of fluids);

- Locally infiltrated anesthesia;

- Nitrous oxide;

- Occupational therapy;

- Paternity testing;

- Plastic or cosmetic procedures for aesthetic purposes;
- Postmortem examinations (autopsy);
- Private duty nursing;
- Professional component service charges for physicians;

NOTE: The professional component shall be billed to the Physician Program of Kentucky Medicaid by the physician who performed the service if he is enrolled as a Medicaid physician provider.

- Services for the treatment of obesity, including gastroplasty, gastric stapling, or ileo-jejunal shunt;
- Services of a research nature or a service which is experimental and not in accordance with customary standards of medical practice or is not commonly used;
- Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment (e.g., transportation of equipment or testing fee);
- Services that require prior-authorization and prior-authorization was not given by the PRO contractor;
- Take home drugs and supplies;
- Telephone calls;
- Thermograms or related procedures; and
- Urinalysis by dipstick (considered part of evaluation and management service.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

A. Ambulatory Surgical Center

The Department for Medicaid Services shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio – Kentucky region to reimburse for an ambulatory surgical center service. Reimbursement shall be the surgical group rate specific to the procedure as established in Appendix F.

Maximum reimbursement for facility services furnished with a covered ASC surgical procedure shall be the provider's billed charges or 100 percent of the surgical group rate, whichever is less. The surgical group classification and maximum reimbursement for each surgical group is listed in Appendix F.

The billed charge to Kentucky Medicaid shall be the same charge for comparable services provided for any party or payor for identical procedures or services.

If there is no surgical group rate available for a procedure, or the Department determines that available data relating to the rate for a procedure is unreliable, the reimbursement shall be forty-five (45) percent of charges. An operative report to support the medical necessity and substantiate the level of service billed shall be attached to all claims submitted when there is not a surgical rate available.

When more than one (1) covered procedure is performed in a single operative session, reimbursement for facility services shall be 100 percent of the surgical group rate for the primary procedure and 50 percent of the surgical group rate for the secondary procedure.

SECTION V - REIMBURSEMENT

B. Laboratory Services

Reimbursement for laboratory services shall be based on the lesser of the providers usual and customary billed charges, or Medicare allowable payment rates. For laboratory codes which have no Medicare allowable fee on file, reimbursement shall be forty-five (45) percent of the usual and customary actual billed charges.

C. Implantables

Implantables are considered part of the surgical procedure. However, implantable cost over one hundred dollars ($100) shall be considered for payment. A cost invoice shall be attached to the claim showing the actual acquistion cost of the implantable by the facility.

D. Reimbursement in Relation to Medicare

1. Deductible and Coinsurance

Deductibles are those medical expenses which the recipient shall initially pay on an annual basis to qualify for subsequent Medicare reimbursement. Coinsurance is a cost-sharing requirement which provides that a recipient shall assume a portion or percentage of the costs of covered services. Medicaid shall pay the Medicare deductible and coinsurance amounts for all Medicare covered services submitted on cross-over claims for eligible recipients.

2. Qualified Medicare Beneficiary

Individuals eligible to receive Medicaid benefits as Qualified Medicare Beneficiaries (QMB's) receive unique, tricolored (red, white, blue) identification cards. Reimbursable services for QMB recipients shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are routinely covered by Kentucky Medicaid.

3. Dual Eligibility for QMB and Medicaid

Individuals eligible for QMB benefits and Medicaid benefits receive a regular white Medical Assistance Identification Card with QMB printed on the front, upper right portion of the card. Medicaid shall pay the Medicare deductible and coinsurance amounts for the time period any recipient is dual eligible.

E. Fees - Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book introduced and published annually by the American Medical Association, this automated system of checking claims shall be utilized to detect miscoding and irregularities, i.e., unbundling which involves billing two (2) or more individual CPT codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in medical technology are introduced and require more specific coding, this automated, claim checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a more closely aligned way consistent with CPT and International Classification of Diseases (ICD-9) criteria.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and mailed to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

SECTION V - REIMBURSEMENT

F. Fee Payment By Recipient

Ambulatory Surgical Center participants in the program shall report **ALL** payments or deposits made toward a recipient's account, regardless of the source of payment. If the center receives payment from an eligible Medicaid Program recipient for a service provided that is a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to payments made by recipients for spenddown or non-covered services.

Recipients approved for Medicaid benefits on a spenddown basis shall be obligated to pay fees to health care providers as assigned by their local Department for Social Insurance where eligibility is established. These fees shall be paid to the providers by the recipients and shall satisfy the excess income for the period of eligibility. These fee payments by the recipients shall be reported by the providers on the claim form as payments from other sources.

Any item(s) or service(s) provided for Medicaid recipients non-covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. Providers shall not collect fees from recipients for covered item(s) or service(s) for which Kentucky Medicaid has made payment. Any payment made by Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

If a recipient has retroactive eligibility in which the individual receives a back-dated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for services during the retroactive eligible period shall require a 100 percent refund to the recipient before the program may be billed.

G. Third Party Coverage Overview

Pursuant to KRS 205.622, all Kentucky Medicaid participating providers shall submit claims for medical services to other responsible parties (e.g., Medicare or other third party insurer) prior to submitting claims to Kentucky Medicaid, when the provider has prior knowledge that another party may be liable for payment of recipient medical services.

Providers' cooperation in reporting other insurers (third parties) and completing Third Party Liability (TPL) Lead Forms accessed from the fiscal agent for Kentucky Medicaid shall enable the Kentucky Medicaid Program to function more cost efficiently. Kentucky Medicaid shall be the payor of last resort.

If a recipient third party insurance is terminated, the recipient shall be required to report the termination to the Department for Social Insurance in the county of residence. Providers identifying the termination shall follow guidelines for the Kentucky Medicaid fiscal agent in reporting terminations identified.

If the recipient has third party resources that cover the medical service, then the provider shall obtain payment or rejection from the third party before a claim against the Medicaid Program can be filed. If payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim.

NOTE: Rejections from insurance carriers stating "additional information necessary to process claim" shall not be acceptable.

H. Identification of Third Party Resources

In order to identify those recipients who may be covered by other health insurance resources, the provider or staff persons shall interview the recipient to substantiate the existence of Medicare or any other insurance. Recipient Medical Assistance Identification (MAID) cards shall reflect information relating to third party resources. Providers may examine the front side of the recipient's **MAID** card for an insurance code.

The following list of insurance identification codes and descriptors appear on the backside of the **MAID** card to assist the provider with identification:

A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
E.- Blue Cross/Blue Shield/Major Medical
F - Private Medical Insurance
G - Champus
H - Health Maintenance Organization
J - Unknown
K - Other
L. - Absent Parent's Insurance
M - None
N - United Mine Workers
P - Black Lung
R - Medicare Part A, Medicare Premium Paid
S - Both Part A & B Medicare Premium Paid

SECTION V - REIMBURSEMENT

I. Third Party Payment/Kentucky Medicaid Payment

Claims meeting the requirements for Medicaid Program payment shall be paid in the following manner when a third party payment is reported to Kentucky Medicaid.

The amount paid by the third party shall be deducted from the Medicaid allowed amount. If third party payment(s) is less than the Kentucky Medicaid allowed amount for the same service and less than the usual and customary billed charge by the provider, Kentucky Medicaid shall allow additional payment amount(s) not to exceed the usual and customary billed charge or its maximum allowable fee for the service. If the third party payment exceeds the Medicaid allowed amount, the resulting Medicaid Program payment shall be zero. Recipients shall not be billed for any difference in health care costs. This Kentucky Medicaid zero payment shall be considered and accepted by the provider as "payment in full" for the service provided.

All providers shall have the choice of billing or not billing Kentucky Medicaid for claims which the provider has prior knowledge of zero payment by Medicaid; however, if the Medicaid Program is billed for the service, the provider shall accept Medicaid payment as payment in full.

Medicaid recipients shall have the right to request itemized account statements from their providers. Itemized statements shall be provided and include any payments made by Kentucky Medicaid or any payments pending Kentucky Medicaid reimbursement.

Medicaid Services Manual

for

Ambulatory Surgical Centers

Appendices

TRANSMITTAL #6
10/02

Services or Procedures Requiring PRO Prior Authorization

The following outpatient elective diagnostic services require Prior Authorization:

1. All Endoscopies (Bronchoscopy, Arthroscopy)
2. Arteriogram
3. Arthrogram
4. MRA (Magnetic Resonance Angrography)
5. MRI (Magnetic Resonance Imaging)
6. Myleogram
7. Stress Thallium (Colonoscopy, etc.)

The following outpatient surgical procedures require Prior Authorization:

1. All unlisted procedures ending in "99"
2. Angiography/Angioplasty
3. Cholecystectomy
4. Colonoscopy
5. Dilation and Curettage (D&C)
6. Electroconvulsive Therapy
7. Endoscopies
8. Epidural Injections
9. Hysteroscopy
10. Laparoscopy
11. Lymphadenectomy
12. Magnetic Resonance Image, Brain, Spine (MRI)
13. Reduction Mammoplasty
14. Septoplasty
15. Skin Lesion (Excision or removal)
16. Skin Tags (removal)
17. Stress Test
18. Thrombectomy/Embolectomy
19. Tonsillectomy and Adenoidectomy

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH (MAP-236)

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, _____, certify that on the basis of
(Physician's Name)

my professioanl judgement, it was necessary to perform the following procedure on _____
(Date)

to induce premature birth intended to produce a live viable child. _____
(Procedure)

This Procedure was necessary for the health of _____
(Name of Mother)

_____ of _____
(MAID #) (Address)

and/or her unborn child.

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

STERILIZATION CONSENT FORM (MAP-250) EXAMPLE

MAP-250
(REV. 5/87)

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Press firmly to assure legible copies

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from John Smith MD (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as Tubal Ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 09 27 70 (Month Day Year).

I, Jane Doe, hereby consent of my own free will to be sterilized by John Smith MD (doctor) by a method called Tubal Ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Jane Doe (Signature) Date 09-1995 (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☒ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter) _____ (Date)

STATEMENT OF PERSON OBTAINING CONSENT

Before Jane Doe (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation Tubal Ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

John Smith MD 09-19-95
(Signature of person obtaining consent) (Date)

123 Lone Oak
(Facility)

Derby, Kentucky 40000
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon Jane Doe (name of individual to be sterilized) on 10 20 95 (Date of sterilization), I explained to him/her the nature of the Tubal Ligation (operation) sterilization operation Tubal Ligation (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

~~(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):~~

- ☐ ~~Premature delivery~~
- ☐ ~~Individual's expected date of delivery:~~
- ☒ ~~Emergency abdominal surgery:~~

~~(describe circumstances):~~

John Smith M.D.
(Physician) (Date) 10-20-95

3. State Agency, Program or Project

U.S. GOVERNMENT PRINTING OFFICE: 1988 O—214-321

HYSTERECTOMY CONSENT FORM (MAP-251) EXAMPLE

MAP-251
(Rev. 4/88)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

HYSTERECTOMY CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO HAVE A HYSTERECTOMY WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I, Jane Doe, *(print or type / patients name)* have requested and received information about hysterectomies (abdominal and/or vaginal) from John Smith, M.D. *(name of attending physician)*

I was informed that a hysterectomy is the surgical removal of the uterus/womb and of the two (2) methods of performing the procedure (abdominal hysterectomy and vaginal hysterectomy).

I have been advised of the type of hysterectomy procedure (abdominal and/ or vaginal) that will be performed on me. I am aware of the complications that may result from the performance of this surgical procedure.

I was informed that a hysterectomy is intended to be a permanent/final and irreversible procedure. I understand that I will be unable to become pregnant or bear children.

I certify that I fully understand the above and voluntarily consent to the surgical procedure.

Signature of Patient/ Representative Jane Doe

Signature of Person Obtaining Consent John Smith

Date October 20, 1995

Press firmly to assure legible copies

ASC FACILITY REIMBURSEMENT RATES

ASC GROUP	REIMBURSEMENT RATE
Group 1	$307.38
Group 2	$412.79
Group 3	$471.90
Group 4	$582.25
Group 5	$664.02
Group 6	$775.59
Group 7	$921.15
Group 8	$911.55